FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037002

Facility Name: Lexington of Streamwood

Address: 815 E. Irving Park Road (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (630) 837-5300 **Fax #** (630) 213-9076

IDPA ID Number: 363748803001

Date of Initial License for Current Owners: 07/08/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,984	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,984	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	35,004	2,778	7,246	45,028	8
9	SNF/PED					9
10	ICF	13,260	1,410	60	14,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,264	4,188	7,306	59,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.89%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/08/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 224 and days of care provided 6,486

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	304,406	27,859	17,083	349,348		349,348		349,348			1
2	Food Purchase		248,914		248,914		248,914	(11,910)	237,004			2
3	Housekeeping	253,083	32,734		285,817		285,817	324	286,141			3
4	Laundry	70,661	25,123		95,784		95,784	(3,887)	91,897			4
5	Heat and Other Utilities			202,372	202,372		202,372	3,703	206,075			5
6	Maintenance	28,530		106,724	135,254		135,254	47,573	182,827			6
7	Other (specify):* Allocated Benefits							5,354	5,354			7
8	**TOTAL General Services**	656,680	334,630	326,179	1,317,489		1,317,489	41,157	1,358,646			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,138,025	252,851	343,561	3,734,437		3,734,437	62,539	3,796,976			10
10a	Therapy			670,991	670,991		670,991		670,991			10a
11	Activities	209,423	19,324	3,467	232,214		232,214		232,214			11
12	Social Services	74,249		2,729	76,978		76,978		76,978			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benefits							7,562	7,562			15
16	**TOTAL Health Care and Programs**	3,421,697	272,175	1,044,748	4,738,620		4,738,620	70,101	4,808,721			16
	C. General Administration											
17	Administrative	82,394		778,243	860,637		860,637	(672,985)	187,652			17
18	Directors Fees											18
19	Professional Services			65,066	65,066		65,066	12,052	77,118			19
20	Dues, Fees, Subscriptions & Promotions			34,039	34,039		34,039	96	34,135			20
21	Clerical & General Office Expenses	235,844	41,724	21,359	298,927		298,927	295,370	594,297			21
22	Employee Benefits & Payroll Taxes			551,945	551,945		551,945	11,714	563,659			22
23	Inservice Training & Education			1,071	1,071		1,071		1,071			23
24	Travel and Seminar			8,808	8,808		8,808	4,039	12,847			24
25	Other Admin. Staff Transportation			3,268	3,268		3,268	10,391	13,659			25
26	Insurance-Prop.Liab.Malpractice			186,507	186,507		186,507	4,626	191,133			26
27	Other (specify):* Allocated Benefits							45,620	45,620			27
28	**TOTAL General Administration**	318,238	41,724	1,650,306	2,010,268		2,010,268	(289,077)	1,721,191			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,396,615	648,529	3,021,233	8,066,377		8,066,377	(177,819)	7,888,558			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Streamwood #0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			56,541	56,541		56,541	184,606	241,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,891	33,891		33,891	266,332	300,223			32
33	Real Estate Taxes							508,365	508,365			33
34	Rent-Facility & Grounds			1,695,343	1,695,343		1,695,343	(1,693,851)	1,492			34
35	Rent-Equipment & Vehicles			8,161	8,161		8,161	3,146	11,307			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,793,936	1,793,936		1,793,936	(731,402)	1,062,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,197		186,197		186,197		186,197			39
40	Barber and Beauty Shops			15,838	15,838		15,838		15,838			40
41	Coffee and Gift Shops			3,191	3,191		3,191		3,191			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* Nonallowable Costs			155,191	155,191		155,191	(155,191)				43
44	**TOTAL Special Cost Centers**		186,197	297,196	483,393		483,393	(155,191)	328,202			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,396,615	834,726	5,112,365	10,343,706		10,343,706	(1,064,412)	9,279,294			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(196)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,887)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,609)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(791)	43		13
14	Non-Care Related Interest	(30,981)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,700)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,937)	43		24
25	Fund Raising, Advertising and Promotional	(13,673)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	112,146			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,629)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(987,783)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (987,783)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,064,412)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Streamwood
Provider #: 0037002
01/01/04 to 12/31/04

Schedule A

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Non-allowable collections and out-of-period legal fees	(7,240)	19
Offset miscellaneous income	(78)	21
Offset miscellaneous non-allowable expenses	(1,714)	21
Offset non-allowable dues and subscriptions	(875)	20
Real estate refund costs	244	33
Nonallowable personal item replacement	(2,060)	43
Offset nonallowable radiology	(7,116)	43
Unrealized gain on fair value of interest rate swap	139,899	43
Offset nonallowable cable	(1,087)	43
Offset nonallowable laboratory	(7,827)	43
	112,146	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(196)	0	0	0	0	0	0	0	0	0	0	(196)	2
3	Housekeeping	0	0	324	0	0	0	0	0	0	0	0	324	3
4	Laundry	(3,887)	0	0	0	0	0	0	0	0	0	0	(3,887)	4
5	Heat and Other Utilities	0	0	3,703	0	0	0	0	0	0	0	0	3,703	5
6	Maintenance	0	0	47,573	0	0	0	0	0	0	0	0	47,573	6
7	Other (specify):*	0	0	5,354	0	0	0	0	0	0	0	0	5,354	7
8	**TOTAL General Services**	(4,083)	0	56,954	0	0	0	0	0	0	0	0	52,871	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	62,539	0	0	0	0	0	0	0	0	62,539	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	7,562	0	0	0	0	0	0	0	0	7,562	15
16	**TOTAL Health Care and Programs**	0	0	70,101	0	0	0	0	0	0	0	0	70,101	16
	C. General Administration													
17	Administrative	0	0	105,258	(778,243)	0	0	0	0	0	0	0	(672,985)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,248	19,172	0	0	0	0	0	0	0	0	30,420	19
20	Fees, Subscriptions & Promotions	0	0	971	0	0	0	0	0	0	0	0	971	20
21	Clerical & General Office Expenses	0	135	297,027	0	0	0	0	0	0	0	0	297,162	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,039	0	0	0	0	0	0	0	0	4,039	24
25	Other Admin. Staff Transportation	0	0	0	10,391	0	0	0	0	0	0	0	10,391	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	4,626	0	0	0	0	0	0	0	4,626	26
27	Other (specify):*	0	0	0	45,620	0	0	0	0	0	0	0	45,620	27
28	**TOTAL General Administration**	0	11,383	426,467	(717,606)	0	0	0	0	0	0	0	(279,756)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,083)	11,383	553,522	(717,606)	0	0	0	0	0	0	0	(156,784)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	153,201	0	31,405	0	0	0	0	0	0	0	184,606	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47,590)	313,542	0	380	0	0	0	0	0	0	0	266,332	32
33	Real Estate Taxes	0	495,343	0	1,650	0	0	0	0	0	0	0	496,993	33
34	Rent-Facility & Grounds	0	(1,695,343)	0	1,492	0	0	0	0	0	0	0	(1,693,851)	34
35	Rent-Equipment & Vehicles	0	0	0	3,146	0	0	0	0	0	0	0	3,146	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(47,590)	(733,257)	0	38,073	0	0	0	0	0	0	0	(742,774)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(137,102)	(139,898)	0	0	0	0	0	0	0	0	0	(277,000)	43
44	TOTAL Special Cost Centers	(137,102)	(139,898)	0	0	0	0	0	0	0	0	0	(277,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(188,775)	(861,772)	553,522	(679,533)	0	0	0	0	0	0	0	(1,176,558)	45

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Streamwood Limited Partnership	Streamwood	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Streamwood Limited Partnership	**	$ 11,248	$ 11,248	1
2	V	21	Bank charges		Sambell of Streamwood Limited Partnership	**	135	135	2
3	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	153,201	153,201	3
4	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	308,574	308,574	4
5	V	32	Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	4,968	4,968	5
6	V	33	Property taxes		Sambell of Streamwood Limited Partnership	**	495,343	495,343	6
7	V	34	Rental expense	1,695,343	Sambell of Streamwood Limited Partnership	**		(1,695,343)	7
8	V	43	State replacement tax		Sambell of Streamwood Limited Partnership	**	1	1	8
9	V	43	Unrealized gain on fmv of interest rate swap		Sambell of Streamwood Limited Partnership	**	(139,899)	(139,899)	9
10	V								10
11	V								11
12	V		** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood Limited Partnership						12
13	V								13
14	Total			$ 1,695,343			$ 833,571	$ * (861,772)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule B**
1/1/04 - 12/31/04

VII. Related Parties

Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Related Nursing Homes	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 324	$ 324	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,521	3,521	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	93	93	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	89	89	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	44,272	44,272	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	3,301	3,301	20
21	V	7	Management allocation - employee benefits		Royal Management Corp.	**	5,354	5,354	21
22	V	10	Management allocation - salaries		Royal Management Corp.	**	62,539	62,539	22
23	V	15	Management allocation - employee benefits		Royal Management Corp.	**	7,562	7,562	23
24	V	17	Management allocation - salaries		Royal Management Corp.	**	105,258	105,258	24
25	V	19	Computer consultant & supplies		Royal Management Corp.	**	11,783	11,783	25
26	V	19	Professional fees		Royal Management Corp.	**	7,389	7,389	26
27	V	20	Dues & subscriptions		Royal Management Corp.	**	871	871	27
28	V	20	Licenses, permits & inspections		Royal Management Corp.	**	23	23	28
29	V	20	Advertising - help wanted		Royal Management Corp.	**	77	77	29
30	V	21	Management allocation - salaries		Royal Management Corp.	**	272,001	272,001	30
31	V	21	Bank charges		Royal Management Corp.	**	2,164	2,164	31
32	V	21	Office supplies & printing		Royal Management Corp.	**	9,192	9,192	32
33	V	21	Postage		Royal Management Corp.	**	3,766	3,766	33
34	V	21	Telephone		Royal Management Corp.	**	9,904	9,904	34
35	V	24	Travel & seminar		Royal Management Corp.	**	4,039	4,039	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 553,522	$ * 553,522	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 10,391	$ 10,391	15
16	V	26	Insurance general		Royal Management Corp.	**	4,626	4,626	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	45,620	45,620	17
18	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,370	3,370	18
19	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,307	7,307	19
20	V	30	Depreciation - equipment		Royal Management Corp.	**	20,728	20,728	20
21	V	32	Interest		Royal Management Corp.	**	380	380	21
22	V	33	Property taxes		Royal Management Corp.	**	1,650	1,650	22
23	V	34	Rent expense		Royal Management Corp.	**	1,492	1,492	23
24	V	35	Equipment rental		Royal Management Corp.	**	3,146	3,146	24
25	V	17	Management fees	778,243	Royal Management Corp.	**		(778,243)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 778,243			$ 98,710	$ * (679,533)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	8%	Salary	$ 35,026	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	3	6%	Salary	25,019	L17, C7	2
3	Cynthia Thiem	Owner/officer	Adminstrative	22.34%	See Schedule C	3	6%	Salary	25,019	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	3%	Salary	6,094	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	14,100	L17, C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 105,258		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/04 - 12/31/04 **Schedule C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	201,824	282,554	201,824	49,160	113,745	849,107

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	$ 2,938	$	81,984	$ 324	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		81,984	3,521	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		81,984	93	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		81,984	89	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	81,984	44,272	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		81,984	3,301	6
7	7	Management allocation - employe	Bed Days	743,346	10	48,540		81,984	5,354	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	81,984	62,539	8
9	15	Management allocation - employe	Bed Days	743,346	10	68,569		81,984	7,562	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	81,984	105,258	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		81,984	11,783	11
12	19	Professional fees	Bed Days	743,346	10	66,993		81,984	7,389	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		81,984	871	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		81,984	23	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		81,984	77	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	81,984	272,001	16
17	21	Bank charges	Bed Days	743,346	10	19,618		81,984	2,164	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		81,984	9,192	18
19	21	Postage	Bed Days	743,346	10	34,142		81,984	3,766	19
20	21	Telephone	Bed Days	743,346	10	89,797		81,984	9,904	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		81,984	4,039	21
22										22
23										23
24										24
25	TOTALS					$ 5,018,749	$ 4,389,035		$ 553,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	$ 94,217	$	81,984	$ 10,391	1
2	26	Insurance general	Bed Days	743,346	10	41,943		81,984	4,626	2
3	27	Management allocation - employe	Bed Days	743,346	10	413,634		81,984	45,620	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557		81,984	3,370	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255		81,984	7,307	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937		81,984	20,728	6
7	32	Interest	Bed Days	743,346	10	3,446		81,984	380	7
8	33	Property taxes	Bed Days	743,346	10	14,963		81,984	1,650	8
9	34	Rent expense	Bed Days	743,346	10	13,526		81,984	1,492	9
10	35	Equipment rental	Bed Days	743,346	10	28,527		81,984	3,146	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 895,005	$		$ 98,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	X		Mortgage	Varies	02/01/96	5,985,000	4,675,415	02/01/2026	Variable	308,574	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working capital	None	Various	1,154,048	1,619,205	Demand	3.0000	30,981	6
7	LaSalle Bank N.A.		X	Working capital	None	4/04/04	900,000	275,000	5/31/05	Prime	2,910	7
8												8
9	TOTAL Facility Related						$ 8,039,048	$ 6,569,620			$ 342,465	9
	B. Non-Facility Related*											
10							Amortization of mortgage costs				4,968	10
11							Interest income offset				(16,609)	11
12							Nonallowable shareholder interest				(30,981)	12
13							Allocated from management company				380	13
14	TOTAL Non-Facility Related						$	$			$ (42,242)	14
15	TOTALS (line 9+line14)						$ 8,039,048	$ 6,569,620			$ 300,223	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 424,200	1
	Allocated from management company	1,650	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 453,831	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,281	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 466,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 11,372	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 732 For 97 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (488)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 508,365	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	448,359	8
	2000	454,959	9
	2001	438,043	10
	2002	444,124	11
2004 assessment: 2,234,400	2003	453,831	12
Est appeal reduc 0.900			
Equalization factor: 2.460			
Tax Rate: 0.094			
Est 03 taxes payable 04: 466,164			
Use: 466,200			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Streamwooc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 453,831.00	$ 453,831.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 187,600.00	$ 1,650.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 641,431.00	$ 455,481.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1991	$ 211,400	1
2	Mgmt. Co.			17,683	2
3	TOTALS	30,000		$ 229,083	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1991	1991	$ 5,248,322	$	35	$ 149,952	$ 149,952	$ 2,024,353	4
5	10		1993	1993	105,236		35	3,007	3,007	31,571	5
6	14		1995	1995	82,650	2,361	35	2,361		22,432	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	2,415	9
10	Land Improvements			1995	7,000	467	15	467		4,435	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		2,992	11
12	Piping			1996	3,139	90	35	90		764	12
13	Basement remodeling			1997	20,204	2,020	10	2,020		14,814	13
14	Floor Repairs			1997	555	56	10	56		396	14
15	Corner Guards			1997	998	100	10	100		708	15
16	Corner Guards			1998	3,563	356	10	356		2,314	16
17	Wiring			1998	2,050	205	10	205		1,333	17
18	Tile			1998	11,696	1,170	10	1,170		7,020	18
19	Patio			1999	12,011	801	15	801		4,072	19
20	Parking lot			2000	1,773	177	10	177		797	20
21	110-ton A/C Unit			2000	6,922	692	10	692		3,114	21
22	Rods for bedside curtains			2000	5,872	587	10	587		2,056	22
23	Automatic Doors			2000	1,300	130	10	130		585	23
24	Rehab project: carpeting, wallcovering, handrails, painting			2000	85,196	8,519	10	8,519		38,336	24
25	Compressor / tube bundles-cooling system			2001	12,922	1,292	10	1,292		4,522	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		37,138	26
27	Parking lot			2002	29,288	2,929	10	2,929		7,322	27
28	Office area rehab			2002	26,991	1,350	20	1,350		3,375	28
29	Elevator interior upgrade			2002	1,120	112	10	112		289	29
30	Gazebo			2002	3,393	339	10	339		848	30
31	Elevator electronic curtains			2002	4,500	450	10	450		1,312	31
32	Door frame protector			2003	5,276	528	10	528		1,012	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring			2003	9,392	939	10	939		1,330	33
34	Roof			2003	29,950	1,498	20	1,498		1,623	34
35	Kitchen Sewer/Dishroom			2004	6,224	207	10	207		207	35
36	Compressor			2004	14,737	246	20	246		246	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Kitchen fire protection upgrade	2004	$ 1,427	$ 107	10	$ 107	$	$ 107	37
38									38
39	Land improvements - management company	2002	27,870		15	1,843	1,843	5,419	39
40	Building - management company	2002	216,828		40	5,300	5,300	15,810	40
41	HVAC, electrical, security system - management company	2003	2,149		30	147	147	204	41
42	Key card system - management company	2004	338		20	17	17	17	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,222,761	$ 38,691		$ 199,167	$ 160,476	$ 2,245,288	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 119,916	$ 13,602	$ 13,602	$	5-10 yrs	$ 61,351	71
72	Current Year Purchases	75,721	1,908	1,908		5-10 yrs	2,015	72
73	Fully Depreciated Assets	491,127	2,372	2,372			491,127	73
74	Allocated from Mgmt. Co.	207,982		20,728	20,728		86,758	74
75	TOTALS	$ 894,746	$ 17,882	$ 38,610	$ 20,728		$ 641,251	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			43,526		3,370	3,370		29,907	79
80	TOTALS			$ 43,526	$	$ 3,370	$ 3,370		$ 29,907	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,390,116	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,573	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,147	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 184,574	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,916,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy room addition	$ 83,524	92
93			93
94			94
95		$ 83,524	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				1,492			6
7	TOTAL				$ 1,492 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 11,307 Description: Copier $7,711 , Fax $270, Mailing Machine $180; Allocated from management company $3,146
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	3,004	$ 219,838	$	3,004	$ 219,838	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		546	39,887		546	39,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,096	401,641		8,096	401,641	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				186,197		186,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound therapy	L10A, C3				9,625			9,625	13
14	TOTAL			$	11,646	$ 670,991	$ 186,197	11,646	$ 857,188	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 37,039	$ 78,930	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 555,000)	1,979,798	1,979,798	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,641	1,641	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,911	762	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,020,389	$ 2,061,131	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	58,309	58,309	12
13	Land		229,083	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	614,682	869,203	15
16	Equipment, at Historical Cost	297,990	938,272	16
17	Accumulated Depreciation (book methods)	(328,110)	(2,916,446)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	83,524	83,524	22
23	Other(specify): Unamortized loan costs		83,031	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 726,395	$ 4,698,534	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,746,784	$ 6,759,665	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 590,263	$ 590,263	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,894,205	1,894,205	29
30	Accrued Salaries Payable	305,557	305,557	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,626	1,626	31
32	Accrued Real Estate Taxes(Sch.IX-B)		466,200	32
33	Accrued Interest Payable		36,284	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	2,177,324	166,057	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,968,975	$ 3,460,192	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,675,415	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap liability		262,164	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,937,579	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,968,975	$ 8,397,771	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,222,191)	$ (1,638,106)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,746,784	$ 6,759,665	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/04 - 12/31/04 **Schedule E**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	2,011,267	-
Accrued management fees	131,568	131,568
Accrued 401 (k) contribution	11,800	11,800
Other accrued expenses	22,689	22,689
Total line 36	2,177,324	166,057

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous income	78
Vending machine commissions	1,380
Investment income in Lexington Financial Services, LLC	1,113
Total line 28	2,571

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (681,154)	1
2	Restatements (describe):		2
3	**Post-closing Adjustments**	(119,201)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (800,355)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,421,836)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,421,836)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,222,191)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,878,093	1
2	Discounts and Allowances for all Levels	(731,024)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,147,069	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,136,278	6
7	Oxygen	266	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,136,544	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,145	12
13	Barber and Beauty Care	19,229	13
14	Non-Patient Meals	196	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	487,513	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,251	19
20	Radiology and X-Ray	10,193	20
21	Other Medical Services	64,663	21
22	Laundry	3,887	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 619,077	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,609	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,609	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	2,571	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,571	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,921,870	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,317,489	31
32	Health Care	4,738,620	32
33	General Administration	2,010,268	33
	B. Capital Expense		
34	Ownership	1,793,936	34
	C. Ancillary Expense		
35	Special Cost Centers	360,417	35
36	Provider Participation Fee	122,976	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,343,706	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,421,836)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,421,836)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,863	2,026	$ 84,220	$ 41.57	1
2	Assistant Director of Nursing	3,968	4,127	121,839	29.52	2
3	Registered Nurses	47,730	51,787	1,424,924	27.52	3
4	Licensed Practical Nurses	13,669	14,932	350,635	23.48	4
5	Nurse Aides & Orderlies	88,325	94,053	1,067,381	11.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,363	6,801	89,026	13.09	8
9	Activity Director	1,919	1,936	27,249	14.07	9
10	Activity Assistants	18,025	19,295	182,174	9.44	10
11	Social Service Workers	3,474	3,930	74,249	18.89	11
12	Dietician	1,856	1,936	27,939	14.43	12
13	Food Service Supervisor	1,988	2,174	30,039	13.82	13
14	Head Cook	1,996	2,243	30,682	13.68	14
15	Cook Helpers/Assistants	10,909	12,099	101,702	8.41	15
16	Dishwashers	17,071	18,207	114,044	6.26	16
17	Maintenance Workers	2,091	2,302	28,530	12.39	17
18	Housekeepers	34,421	37,283	253,083	6.79	18
19	Laundry	10,413	11,049	70,661	6.40	19
20	Administrator	1,912	2,140	82,394	38.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,283	16,681	235,844	14.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,276	305,001	$ 4,396,615 *	$ 14.42	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	267	$ 17,083	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	16	877	L10, C3	37
38	Nurse Consultant	79	6,933	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,467	L11, C3	44
45	Social Service Consultant	15	2,729	L12, C3	45
46	Other(specify)				46
47	Rehabcare	Monthly	32	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	377	$ 56,321		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,089	$ 152,225	L10, C3	50
51	Licensed Practical Nurses	2,719	59,815	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8,808	$ 212,040		53

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dallas Larson	Administrator	0.00%	$ 82,394
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,394

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 778,243
TOTAL (agree to Schedule V, line 17, col. 3)	$ 778,243
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 21,322
Amalgamated	Bond Admin Fee	475
American Express Tax & Bus. Svcs.	Accounting	6,304
Avail Corporation	Accounting	969
Freedman, Anselmo & Lindberg	Collections	233
Grabowski Law Center, LLC	Collections	5,978
Carilyn Jeschke	Staffing Consultant	1,556
Moody's	Bond Rating Fee	554
Personnel Planners	U/C Consulting	2,145
James Samatas, Atty at Law	Legal	179
Sachnoff & Weaver	Legal	12,171
See attached Schedule F		13,180
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 65,066

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,627
Unemployment Compensation Insurance	34,908
FICA Taxes	325,774
Employee Health Insurance	89,971
Employee Meals	11,714
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	9,156
Other Employee Benefits	21,509
TOTAL (agree to Schedule V, line 22, col.8)	$ 563,659

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,240
Advertising: Employee Recruitment	25,370
Health Care Worker Background Check	
(Indicate # of checks performed 83)	1,000
Miscellaneous Licenses & Permits	3,554
Allocated from management company	971
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	110
Seminar Expense	8,698
Allocated from management company	4,039
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,847

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule F**
1/1/04 - 12/31/04

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
KMZRosenman	Legal	1,264
Scott & Krause	Legal	973
Advanced Answers on Demand	Computer consulting	2,652
Lanac	Computer consulting	792
Gigatrend	Computer consulting	195
Telenet Communications	Computer consulting	208
National Datacare	Computer consulting	1,659
AdminaStar Federal fee	Computer consulting	396
E Health Solutions	Computer consulting	3,600
McLeod USA	Computer consulting	285
Information Controls, Inc.	Computer consulting	1,156
		13,180
Total, Agrees to Schedule V, Line 19, Column 3		65,066
Allocated from management co.		
American Express Tax & Business Services	Accounting	335
Altschuler, Melvoin & Glasser LLP	Accounting	534
AccountTemps	Accounting	912
Avail Corporation	Accounting	26
Gilson, Labus and Silverman	Accounting	276
Doris Fischer	Medicaid Billing Consultant	2,348
James Samatas	Legal	39
Sachnoff and Weaver	Legal	1,095
ING / Pension Administrators	401 (k) Administration	959
Personal Planners	U/C Consulting	13
Susan Parker, LCSW	DNR Consulting	12
Eric Hader	Consultant	29
Gene Whitehorn	Medicaid Billing Consultant	811
Various	Computer Consulting	11,783
Allocated from building partnership		
James Samatas	Filing and recording fees	120
McCracken, Walsh, DeLavan & Hetler	Real estate tax appeal fees	9,130
Dennis W. Hetler & Associates	Real estate tax appeal fees	1,998
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(233)
Grabowski Law Center, LLC	Legal-collection fees	(5,978)
Katten, Muchin, Zavis and Rosenman	Legal-out of period fees	(1,029)
Reclassifications		
Dennis W. Hetler & Associates	Real estate tax appeal costs	(1,998)
McCracken, Walsh, DeLavan & Hetler	Real estate tax appeal costs	(9,130)
Total, Agrees to Schedule V, Line 19, Column 8		77,118

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$ N/A	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,650** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,976**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,714** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **196**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	304,406	27,859	17,083	349,348	0	349,348	0	349,348
2. Food Purchase	0	248,914	0	248,914	0	248,914	-11,910	237,004
3. Housekeeping	253,083	32,734	0	285,817	0	285,817	324	286,141
4. Laundry	70,661	25,123	0	95,784	0	95,784	-3,887	91,897
5. Heat and Other Utilities	0	0	202,372	202,372	0	202,372	3,703	206,075
6. Maintenance	28,530	0	106,724	135,254	0	135,254	47,573	182,827
7. Other (specify)*	0	0	0	0	0	0	5,354	5,354
8. Total General Services	656,680	334,630	326,179	1,317,489	0	1,317,489	41,157	1,358,646
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	3,138,025	252,851	343,561	3,734,437	0	3,734,437	62,539	3,796,976
10a. Therapy	0	0	670,991	670,991	0	670,991	0	670,991
11. Activities	209,423	19,324	3,467	232,214	0	232,214	0	232,214
12. Social Services	74,249	0	2,729	76,978	0	76,978	0	76,978
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,562	7,562
16. Total Health Care & Programs	3,421,697	272,175	1,044,748	4,738,620	0	4,738,620	70,101	4,808,721
17. Administrative	82,394	0	778,243	860,637	0	860,637	-672,985	187,652
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	65,066	65,066	0	65,066	12,052	77,118
20. Fees, Subscriptions & Promotion	0	0	34,039	34,039	0	34,039	96	34,135
21. Clerical & General Office	235,844	41,724	21,359	298,927	0	298,927	295,370	594,297
22. Employee Benefits & Payroll	0	0	551,945	551,945	0	551,945	11,714	563,659
23. Inservice Training & Education	0	0	1,071	1,071	0	1,071	0	1,071
24. Travel and Seminar	0	0	8,808	8,808	0	8,808	4,039	12,847
25. Other Admin. Staff Trans	0	0	3,268	3,268	0	3,268	10,391	13,659
26. Insurance-Prop.Liab.Malpractice	0	0	186,507	186,507	0	186,507	4,626	191,133
27. Other (specify)*	0	0	0	0	0	0	45,620	45,620
28. Total General Adminis	318,238	41,724	1,650,306	2,010,268	0	2,010,268	-289,077	1,721,191
29. Total General Administrative	4,396,615	648,529	3,021,233	8,066,377	0	8,066,377	-177,819	7,888,558
30. Depreciation	0	0	56,541	56,541	0	56,541	184,606	241,147
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	33,891	33,891	0	33,891	266,332	300,223
33. Real Estate	0	0	0	0	0	0	508,365	508,365
34. Rent - Facility & Grounds	0	0	1,695,343	1,695,343	0	1,695,343	-1,693,851	1,492
35. Rent - Equipment & Vehicles	0	0	8,161	8,161	0	8,161	3,146	11,307
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,793,936	1,793,936	0	1,793,936	-731,402	1,062,534
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	186,197	0	186,197	0	186,197	0	186,197
40. Barber and Beauty Shop	0	0	15,838	15,838	0	15,838	0	15,838
41. Coffee and Gift Shops	0	0	3,191	3,191	0	3,191	0	3,191
42. Provider Participation	0	0	122,976	122,976	0	122,976	0	122,976
43. Other (specify):*	0	0	155,191	155,191	0	155,191	-155,191	0
44. Total Special Cost Ce	0	186,197	297,196	483,393	0	483,393	-155,191	328,202
45. Grand Total	4,396,615	834,726	5,112,365	10,343,706	0	10,343,706	-1,064,412	9,279,294

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	37,039	78,930
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,979,798	1,979,798
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,641	1,641
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	1,911	762
9. Other (specify):	0	0
10. Total current assets	2,020,389	2,061,131
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	58,309	58,309
13. Land	0	229,083
14. Buildings, at Historical Cost	0	5,353,558
15. Leasehold Improvements, Historical Cost	614,682	869,203
16. Equipment, at Historical Cost	297,990	938,272
17. Accumulated Depreciation (book methods)	-328,110	-2,916,446
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	83,524	83,524
23. other (specify):	0	83,031
24. Total Long-Term Assets	726,395	4,698,534
25. Total Assets	2,746,784	6,759,665
CURRENT LIABILITIES		
26. Accounts Payable	590,263	590,263
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,894,205	1,894,205
30. Accrued Salaries Payable	305,557	305,557
31. Accrued Taxes Payable	1,626	1,626
32. Accrued Real Estate Taxes	0	466,200
33. Accrued Interest Payable	0	36,284
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,177,324	166,057
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	4,968,975	3,460,192
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,675,415
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	262,164
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,937,579
46.Total Liabilities	4,968,975	8,397,771
47.Total Equity	-2,222,191	-1,638,106
48.Total Liabilities and Equity	2,746,784	6,759,665

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,878,093
2. Discounts and Allowances for all Levels	-731,024
Subtotal - Inpatient Care	7,147,069
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,136,278
7. Oxygen	266
Subtotal - Anciliary Revenue	1,136,544
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	3,145
13. Barber and Beauty Care	19,229
14. Non-Patient Meals	196
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	487,513
18. Sale of Supplies to Non-Patients	0
19. Laboratory	30,251
20. Radiologyand X-Ray	10,193
21. Other Medical Services	64,663
22. Laundry	3,887
Subtotal - Other Operating Revenue	619,077
24. Contributions	0
25. Interest and Other Investments Income	16,609
Subtotal - Non-Operating Revenue	16,609
27. Other Revenue (specify):	0
28. Other Revenue (specify):	2571
Subtotal - Other Revenue	2,571
30. Total Revenue	8,921,870
31. General Services	1,317,489
32. Health Care	4,738,620
33. General Administration	2,010,268
34. Ownership	1,793,936
35. Special Cost Centers	360,417
35. Provider Participation Fee	122,976
37. Other	0
40. Total Expenses	10,343,706
41. Income Before Income Taxes	-1,421,836
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,421,836

Page